FOREIGN MEDICAL GRADUATES:

IN ORDER TO EXPEDITE THE DIRECT SOURCE VERIFICATION OF YOUR MEDICAL SCHOOL DEGREE, YOU NEED TO COMPLETE THE TOP PORTION OF THE ATTACHED FORM, ATTACH A PASSPORT SIZE PHOTOGRAPH OF YOURSELF IN THE BOTTOM PORTION OF THE FORM AND SEND THE FORM TO YOUR MEDICAL SCHOOL. THE MEDICAL SCHOOL WILL NEED TO COMPLETE THE LOWER PORTION OF THE FORM AND SEND THE FORM DIRECTLY TO OUR OFFICE.

SUBSTITUTIONS FOR THIS FORM WILL NOT BE ACCEPTED. PHOTOGRAPH MUST BE INCLUDED AND VERIFIED BY SCHOOL.

THIS FORM IS FOR FOREIGN MEDICAL GRADUATES ONLY.

Graduates of US or Canadian schools, please have your school send a certified final transcript or letter indicating date graduated and degree received.

State of Nebraska Department of Health and Human Services
Regulation and Licensure Credentialing Division
PO Box 94986, Lincoln NE 68509-4986 (402) 471-2118

VERIFICATION OF FOREIGN MEDICAL COLLEGE

_____
Name of University

_____
Street

_____
City State Zip

I, _____, MD/DO have applied for a license to practice in the State of
(Print full name)
Nebraska. As part of the application process, the State of Nebraska requires a verification of my Foreign Medical College.

I hereby authorize _____, its staff or representative to provide the State of
(Name of College)
Nebraska any and all information requested below, whether such information is favorable or unfavorable, and I hereby release from any and all liability the above named society and/or person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice. Further, I request that this completed form be sent directly to the State of Nebraska. I understand that completed forms returned to me will not be accepted for verification purposes.

Sincerely, _____ Date of Birth _____/_____/_____
(Signature of Applicant) MO DAY YEAR

Social Security Number _____ Date of Graduation _____/_____/_____
MO DAY YEAR

For verification of FOREIGN MEDICAL COLLEGE ONLY. Please provide exact dates. The following section must be completed by the dean or registrar of the foreign medical school and returned directly to the State of Nebraska. Verifications returned directly to the applicant will not be accepted. Do not complete if photograph is not attached. Any substitutions must contain all required information or it will not be accepted for verification purposes.

This certifies that _____
(full name of applicant)

Enrolled in _____
(Name of Foreign Medical College)

on _____/_____/_____ graduated _____/_____/_____
MO DAY YEAR MO DAY YEAR

and received the **DEGREE** of _____

Any disciplinary action on file? Yes (please explain)_____ No _____

Further, the records of this institution indicate that the attached photograph
(check one) _____ Represents a true likeness of the above named applicant
_____Does not represent a true likeness of the above-named applicant.

By _____ SEAL Attach
Original Signature of the dean or registrar Passport size
(stamped or electronic signatures will NOT be accepted) Photograph Here

_____
Print or Type Official's Name and Title

_____
e-mail address if possible

Signed and the college Seal affixed on _____/_____/_____ Medical College seal MUST be imprinted partially on photograph
MO Day Year